

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007807

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

231

Primary Registration District No.

Registrar's No.

31

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY NODAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE IOWA b. COUNTY PAGE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ELMO		c. CITY OR TOWN COLLEGE SPRINGS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FORD HOSPITAL		d. STREET ADDRESS NONE IN TOWN	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES ELDON GIBSON		4. DATE OF DEATH Month Day Year JAN. 19, 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
11a. FATHER'S NAME JOHN W. GIBSON		11b. MOTHER'S MAIDEN NAME ANNIE ELGIN	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of) NO		12b. SOCIAL SECURITY NO. 5	
13. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and debilitation.		14. NAME OF HUSBAND OR WIFE MARY E. GIBSON	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks.	
DUE TO (c) Primary site probably in stomach.		few months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION ELMO, MISSOURI		
21. I attended the deceased from June 29, 1962 to January 19, 1963 and last saw him alive on Jan. 19, 1963		22. SIGNATURE <i>Harmon Ford</i> D.D.O.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REM. & BUR		23b. DATE 1/22/1963	
23c. NAME OF CEMETERY OR CREMATORY MAPLE HILL		23d. LOCATION (City, town, or county) (State) COLLEGE SPRINGS, IOWA	
24. FUNERAL DIRECTOR Loren Dawson		25. DATE RECD. BY LOCAL REG. 2/11/63	
26. REGISTRAR'S SIGNATURE <i>Bess Holt</i>		27. ADDRESS CLARINDA, IA.	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by Boyd G. Nowinger, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Boyd G. Nowinger

Licensed Embalmer No. 5136 MO.

P. O. Address Bedford, Iowa

I Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.